		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045070

Facility Name: GREENWOOD TERRACE NRSG & REHAB

Address: 225 CASTELLANO DRIVE (Number) SWANSEA (City) 62226 (Zip Code)

County: ST. CLAIR

Telephone Number: (618)235-1300 **Fax #** (847)235-1208

IDPA ID Number: 36-4384101

Date of Initial License for Current Owners: 10/15/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/23/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	97	37,277	1
2		Skilled Pediatric (SNF/PED)			2
3	132	Intermediate (ICF)	78	41,106	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	175	78,383	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,380		3,544	5,924	8
9	SNF/PED					9
10	ICF	24,064	8,541	1,050	33,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,444	8,541	4,594	39,579	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.49%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/15/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/15/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,317

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHA # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	207,464	20,614	22,967	251,045		251,045		251,045			1
2	Food Purchase		157,130		157,130		157,130	(4,721)	152,409			2
3	Housekeeping	157,082	29,879		186,961		186,961		186,961			3
4	Laundry	82,342	16,316	3,700	102,358		102,358		102,358			4
5	Heat and Other Utilities			104,302	104,302		104,302		104,302			5
6	Maintenance	86,859	54,209	83,726	224,794		224,794	(2,696)	222,098			6
7	Other (specify):*			16,141	16,141		16,141		16,141			7
8	**TOTAL General Services**	533,747	278,148	230,836	1,042,731		1,042,731	(7,417)	1,035,314			8
	B. Health Care and Programs											
9	Medical Director			6,925	6,925		6,925		6,925			9
10	Nursing and Medical Records	1,657,648	70,252	35,102	1,763,002		1,763,002	7,611	1,770,613			10
10a	Therapy	126,640		11,115	137,755		137,755		137,755			10a
11	Activities	64,010	2,788	3,253	70,051		70,051		70,051			11
12	Social Services	44,155		3,321	47,476		47,476		47,476			12
13	Nurse Aide Training											13
14	Program Transportation			28	28		28		28			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,892,453	73,040	59,744	2,025,237		2,025,237	7,611	2,032,848			16
	C. General Administration											
17	Administrative	90,736		327,685	418,421		418,421	(316,057)	102,364			17
18	Directors Fees											18
19	Professional Services			160,725	160,725		160,725	8,056	168,781			19
20	Dues, Fees, Subscriptions & Promotions			125,237	125,237		125,237	(76,311)	48,926			20
21	Clerical & General Office Expenses	162,715	30,690	113,482	306,887		306,887	42,261	349,148			21
22	Employee Benefits & Payroll Taxes			391,832	391,832		391,832		391,832			22
23	Inservice Training & Education			4,166	4,166		4,166		4,166			23
24	Travel and Seminar			4,281	4,281		4,281	6,069	10,350			24
25	Other Admin. Staff Transportation			15,763	15,763		15,763		15,763			25
26	Insurance-Prop.Liab.Malpractice			156,809	156,809		156,809	3,535	160,344			26
27	Other (specify):*			107,824	107,824		107,824	(107,824)				27
28	**TOTAL General Administration**	253,451	30,690	1,407,804	1,691,945		1,691,945	(440,271)	1,251,674			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,679,651	381,878	1,698,384	4,759,913		4,759,913	(440,077)	4,319,836			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB #0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			106,143	106,143		106,143	122,563	228,706			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			84,969	84,969		84,969	209,021	293,990			32
33	Real Estate Taxes			48,078	48,078		48,078		48,078			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(288,673)	11,327			34
35	Rent-Equipment & Vehicles			17,450	17,450		17,450	5,225	22,675			35
36	Other (specify):*											36
37	**TOTAL Ownership**			556,640	556,640		556,640	48,136	604,776			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,471	383,743	454,214		454,214		454,214			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,574	117,574		117,574		117,574			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		70,471	501,317	571,788		571,788		571,788			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,679,651	452,349	2,756,341	5,888,341		5,888,341	(391,941)	5,496,400			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(74,641)	30		9
10	Interest and Other Investment Income	(243)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,721)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(69,913)	21		18
19	Entertainment	(36,057)	20		19
20	Contributions	(2,750)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,305)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,824)	27		24
25	Fund Raising, Advertising and Promotional	(30,071)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,526)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(2,696)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (338,747)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(53,194)	PG6&6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (53,194)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (391,941)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
GREENWOOD TERRACE NRSG & REHAB
ID# 0045070
Report Period Beginning: 01/01/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (2,696)	6	1
2	VACATION ACCRUAL		1	2
3	VACATION ACCRUAL		3	3
4	VACATION ACCRUAL		6	4
5	VACATION ACCRUAL		10	5
6	VACATION ACCRUAL		11	6
7	VACATION ACCRUAL		21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,696)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,721)	0	0	0	0	0	0	0	0	0	0	(4,721)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,696)	0	0	0	0	0	0	0	0	0	0	(2,696)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,417)	0	0	0	0	0	0	0	0	0	0	(7,417)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,611	0	0	0	0	0	0	0	0	0	7,611	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	7,611	0	0	0	0	0	0	0	0	0	7,611	16
	C. General Administration													
17	Administrative	0	(316,057)	0	0	0	0	0	0	0	0	0	(316,057)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,305)	3,781	5,580	0	0	0	0	0	0	0	0	8,056	19
20	Fees, Subscriptions & Promotions	(77,404)	1,093	0	0	0	0	0	0	0	0	0	(76,311)	20
21	Clerical & General Office Expenses	(69,913)	112,174	0	0	0	0	0	0	0	0	0	42,261	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,069	0	0	0	0	0	0	0	0	0	6,069	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,535	0	0	0	0	0	0	0	0	0	3,535	26
27	Other (specify):*	(107,824)	0	0	0	0	0	0	0	0	0	0	(107,824)	27
28	**TOTAL General Administration**	(256,446)	(189,405)	5,580	0	0	0	0	0	0	0	0	(440,271)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(263,863)	(181,794)	5,580	0	0	0	0	0	0	0	0	(440,077)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB **#** 0045070 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(74,641)	4,132	193,072	0	0	0	0	0	0	0	0	122,563	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(243)	0	209,264	0	0	0	0	0	0	0	0	209,021	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,327	(300,000)	0	0	0	0	0	0	0	0	(288,673)	34
35	Rent-Equipment & Vehicles	0	5,225	0	0	0	0	0	0	0	0	0	5,225	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(74,884)	20,684	102,336	0	0	0	0	0	0	0	0	48,136	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(338,747)	(161,110)	107,916	0	0	0	0	0	0	0	0	(391,941)	45

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					MORTON GROVE	
				CASTLEHAVEN AGENCY		REAL ESTATE
					MORTON GROVE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 7,611	$ 7,611	1
2	V	17	ADMINISTRATIVE	327,685	MR. BELLOWS OWNS 100% OF THIS FACILITY		11,628	(316,057)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,781	3,781	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,093	1,093	4
5	V	21	CLERICAL		" "		112,174	112,174	5
6	V	24	TRAVEL		" "		6,069	6,069	6
7	V	26	INSURANCE		" "		3,535	3,535	7
8	V	30	DEPRECIATION		" "		4,132	4,132	8
9	V	34	RENT		" "		11,327	11,327	9
10	V	35	RENT-EQUIPMENT & VEH		" "		5,225	5,225	10
11	V								11
12	V								12
13	V								13
14	Total			$ 327,685			$ 166,575	$ * (161,110)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 300,000	CASTLEHAVEN AGENCY		$	$ (300,000)	15
16	V	19	ACCOUNTING FEES						16
17	V	19	LEGAL				5,580	5,580	17
18	V	19	OTHER PROFESSIONAL						18
19	V	30	DEPRECIATION				193,072	193,072	19
20	V	32	INTEREST-MORTGAGE				209,264	209,264	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 300,000			$ 407,916	$ * 107,916	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHA # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT.	ADMIN.	100%	SEE ATTACHED	1.93	7.97	SALARY	11,628	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,628		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	496,459	9	$ 95,479	$ 95,479	39,579	$ 7,611	1
2	17	ADMINISTRATIVE	PATIENT DAYS	496,459	9	145,864	145,864	39,579	11,628	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	496,459	9	47,431		39,579	3,781	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	496,459	9	13,714		39,579	1,093	4
5	21	CLERICAL	PATIENT DAYS	496,459	9	190,601		39,579	15,195	5
6	21	CLERICAL	DIRECT COST	1	1	96,979	96,979	1	96,979	6
7	24	TRAVEL	PATIENT DAYS	496,459	9	76,130		39,579	6,069	7
8	26	INSURANCE	PATIENT DAYS	496,459	9	44,347		39,579	3,535	8
9	30	DEPRECIATION	PATIENT DAYS	496,459	9	51,835		39,579	4,132	9
10	34	RENT	PATIENT DAYS	496,459	9	142,084		39,579	11,327	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	496,459	9	65,539		39,579	5,225	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 970,003	$ 338,322		$ 166,575	25

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHA] # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	ALBANY BANK		X	MORTGAGE	$29,523.00		$ 3,500,000	$ 3,294,843		0.0625	$ 209,264	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	DEMAND	04/01	450,000	4,795,206	DEMAND	PRIME+	43,424	6
7	RELATED PARTY	X		WORKING CAPITAL	DEMAND	VARIES	90,000	846,979	DEMAND	VARIES	41,545	7
8												8
9	TOTAL Facility Related				$29,523.00		$ 4,040,000	$ 8,937,028			$ 294,233	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,040,000	$ 8,937,028			$ 294,233	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 46,680	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 47,118	2
3. Under or (over) accrual (line 2 minus line 1).		$ 438	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 47,640	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 48,078	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000	46,173	11
2001	47,118	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GREENWOOD TERRACE NRSG & REHAB COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0045070

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-15.0-103-001	NURSING HOME	$ 47,117.56	$ 47,117.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,117.56	$ 47,117.56

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 66,190 B. General Construction Type: Exterior BRICK VENEER Frame MASONRY Number of Stories 1/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	285,600		$	1
2					2
3	TOTALS	285,600		$	3

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	175		1994		$ 6,052,732	$ 193,072	27.5	$ 193,072	$	$ 1,555,803	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VENTILATOR ROOF			2001	3,832	140	27.5	140			9
10	200 YDS CUSTOM CARPETS/DRAPES/WALLCOVERING-MN DI			2001	24,870	1,243	20	1,243			10
11	WALL AIR CONDITIONER			2001	5,583	203	27.5	203			11
12	BORDERS/TILES/WALLCOVERING-FRONT LOBBY & CORRIDOR			2001	9,057	453	20	453			12
13	MULCH, ROCK, BRICK, FABRIC PLANTS - LANDSCAPING			2001	4,212	281	15	281			13
14	WALL COVERING/CARPETS/CUBICLE CURTAINS/VCT TILES			2001	22,334	1,117	20	1,117			14
15	REMOVE, PRIME AND HANG NEW WALL COVERINGS			2001	32,762	1,638	20	1,638			15
16	PAINTED AND PREP. RESIDENT ROOMS - 200 WING			2001	6,728	336	20	336			16
17	PREP DRYWALL, PAINT HALLWAYS, CORRIDORS & DOORS			2002	44,569	675	27.5	675			17
18	SEWER REPAIRS			2002	3,600	98	27.5	98			18
19	CARPET LOBBY, OFFICES, AND RESIDENT ROOMS			2002	17,532	7,714	5	1,753	(5,961)		19
20	AWNINGS FOR THE ENTRANCEWAY			2002	4,076	25	27.5	25			20
21	INSTALL SINKS & FAUCETS IN WASHROOMS IN RES. ROOMS			2002	11,054	100	27.5	100			21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,242,941	$ 207,095		$ 201,134	$ (5,961)	$ 1,555,803	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 139,571	$ 42,085	$ 17,754	$ (24,331)	3-10 YRS	$ 37,915	71
72	Current Year Purchases	113,716	50,035	5,686	(44,349)	3-10 YRS	5,686	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	32,379	4,132	4,132			5,210	74
75	TOTALS	$ 285,666	$ 96,252	$ 27,572	$ (68,680)		$ 48,811	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,528,607	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 303,347	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,706	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (74,641)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,604,614	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 17,450 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 141,886	$		$ 141,886	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			90,581			90,581	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			151,211			151,211	4
5	Physician Care	39-3	visits			65			65	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				56,389		56,389	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	X-RAY, LAB, RENTALS, I.V. THERAPY Other (specify):	39-2					14,082		14,082	13
14	TOTAL			$		$ 383,743	$ 70,471		$ 454,214	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 52,869	$ 832,947	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 16,095)	1,533,833	1,533,833	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,441	69,441	6
7	Other Prepaid Expenses	19,015	19,015	7
8	Accounts Receivable (owners or related parties)	135,801	174,317	8
9	Other(specify): ESCROW DEPOSITS		15,793	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,810,959	$ 2,645,346	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		885,249	13
14	Buildings, at Historical Cost		6,052,732	14
15	Leasehold Improvements, at Historical Cost	190,207	190,207	15
16	Equipment, at Historical Cost	253,287	592,189	16
17	Accumulated Depreciation (book methods)	(146,480)	(2,041,185)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 297,014	$ 5,679,192	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,107,973	$ 8,324,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 316,401	$ 316,401	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	110,255	110,255	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,447	76,447	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,132	20,132	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,640	47,640	32
33	Accrued Interest Payable	1,132	1,132	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES			36
37	RENT PAYABLE			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 572,007	$ 572,007	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,642,185	8,556,685	39
40	Mortgage Payable		3,294,843	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,642,185	$ 11,851,528	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,214,192	$ 12,423,535	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,106,219)	$ (4,098,997)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,107,973	$ 8,324,538	48

***(See instructions.)**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,297,273)	1
2	Restatements (describe):		2
3	ROUNDING ADJ	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,297,275)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,808,944)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,808,944)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (4,106,219)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,076,619	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,076,619	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	243	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 243	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**NET VENDING SOMMISSIONS**	2,535	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,079,397	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,042,731	31
32	Health Care	2,025,237	32
33	General Administration	1,691,945	33
	B. Capital Expense		
34	Ownership	556,640	34
	C. Ancillary Expense		
35	Special Cost Centers	454,214	35
36	Provider Participation Fee	117,574	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,888,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,808,944)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,808,944)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,872	3,038	$ 72,742	$ 23.94	1
2	Assistant Director of Nursing	1,442	1,519	37,101	24.42	2
3	Registered Nurses	6,343	6,426	141,972	22.09	3
4	Licensed Practical Nurses	32,494	34,075	602,656	17.69	4
5	Nurse Aides & Orderlies	72,936	75,530	775,485	10.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,720	9,466	126,640	13.38	8
9	Activity Director	2,056	2,166	25,444	11.75	9
10	Activity Assistants	4,700	4,989	38,566	7.73	10
11	Social Service Workers	3,676	3,925	44,155	11.25	11
12	Dietician					12
13	Food Service Supervisor	2,035	2,152	43,314	20.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,401	21,084	164,150	7.79	15
16	Dishwashers					16
17	Maintenance Workers	6,277	6,549	86,859	13.26	17
18	Housekeepers	18,261	18,782	157,082	8.36	18
19	Laundry	10,842	11,021	82,342	7.47	19
20	Administrator	2,077	2,326	75,341	32.39	20
21	Assistant Administrator	682	847	15,395	18.18	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,175	9,031	162,715	18.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,448	2,514	27,692	11.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,437	215,440	$ 2,679,651 *	$ 12.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	524	$ 22,848	1-3	35
36	Medical Director	60	6,925	9-3	36
37	Medical Records Consultant	45	1,775	10-3	37
38	Nurse Consultant	738	25,763	10-3	38
39	Pharmacist Consultant	152	1,000	10-3	39
40	Physical Therapy Consultant	175	7,875	10a-3	40
41	Occupational Therapy Consultant	72	3,240	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	61	3,253	11-3	44
45	Social Service Consultant	62	3,321	12-3	45
46	Other(specify) ALZHEIMERS	147	6,564	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,036	$ 82,564		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LINDA SIMMONS	ADMIN		$ 75,341
BRIAN KOONTZ	ASST ADMIN		15,395
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,736

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 327,685
TOTAL (agree to Schedule V, line 17, col. 3)		$ 327,685
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		160,725
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 160,725

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 4,245
Unemployment Compensation Insurance		61,858
FICA Taxes		204,799
Employee Health Insurance		115,508
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		5,422
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 391,832

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	42,170
Health Care Worker Background Check	3,270
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	74,654
TRUST/FRANCHISE/CONTRIB/ETC	2,750
LICENSES & PERMITS	330
DUES & SUBSCRIPTIONS	2,063
MGMT CO ALLOCATION	1,093
TRUST/FRANCHISE/CONTRIB/ETC	(2,750)
Less: Public Relations Expense	(36,057)
Non-allowable advertising	(30,071)
Yellow page advertising	(8,526)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,926

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	4,281
RELATED PARTY	6,069
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,350

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	06/2001	$ 3,606	3	$	$	$ 601	$ 1,202	$ 1,202	$ 601	$	$	$
2	PAINT/DECORATING	06/2002	4,677	3				779	1,559	1,559	780		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,283		$	$	$ 601	$ 1,981	$ 2,761	$ 2,160	$ 780	$	$

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB # 0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,449** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **117,574**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GREENWOOD TERRACE NRSG & REHAB #0045070 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	22,848	
	REPAIRS & MAINTENANCE		119	
			0	22,967
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,700	
			0	3,700
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,584	
	ELECTRICITY		55,300	
	WATER		24,418	
	CABLE TV - LOBBY		0	
			0	104,302
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		14,259	
	PAINTING & DECORATING		4,677	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		1,634	
	EQUIPMENT MAINTENANCE & REPAIR		5,326	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		45,128	
	EXTERMINATING SERVICE		4,260	
	FIRE SERVICE		8,442	
			0	
			0	
			0	83,726
7	**OTHER**			
	SCAVENGER		15,647	
	SECURITY SERVICE		494	16,141
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,925	6,925

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,775	
	PHARMACY CONSULTANT	XVIII B 39-2	1,000	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	25,763	
	ALZHEIMERS CONSULTANT	XVIII B 46-2	6,564	
			0	35,102
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,875	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,240	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	11,115
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,253	
			0	3,253
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,321	
			0	3,321
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GREENWOOD TERRACE NRSG & REHAB #0045070 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		28	28
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	327,685	327,685
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	20,559	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	140,166	
			0	160,725
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	36,057	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	30,071	
	EMPLOYEE WANT ADS	XIX F	42,170	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	2,063	
	LICENSES & PERMITS	XIX F	330	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	8,526	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,600	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	3,270	125,237
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,354	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	69,913	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		776	
	TELEPHONE		36,216	
	MESSENGER SERVICE		1,223	
			0	113,482

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	204,799	
	UNEMPLOYMENT COMPENSATION	XIX D	61,858	
	WORKERS COMPENSATION INSURANC	XIX D	4,245	
	HOSPITALIZATION INSURANCE	XIX D	115,508	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,422	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	391,832
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,166	4,166
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	4,281	
			0	
			0	4,281
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,763	15,763
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		156,809	156,809
27	**OTHER**			
	BAD DEBTS	VI 24	107,824	
			0	107,824

GRAND TOTAL COLUMN 3 OTHER 1,698,384

GREENWOOD TERRACE NRSG & REHAB
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	157,130	PATIENT MEALS	118737
LESS SALES TAX	(4,721)	ADD EMPLOYEE MEALS	0
NET FOOD	152,409	TOTAL MEALS/YEAR	118737
TOTAL PATIENT CENSUS	39,579	NET FOOD	152409
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	118737
TOTAL PATIENT MEALS	118737	COST PER MEAL	1.28
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

GREENWOOD TERRACE NRSG & REHAB
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										4,096,067	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		2,025,237	391,832	532,198	102,358	408,175	1,300,113	117,574	556,640		2,679,651
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	5,145		3,019			9,286		(17,450)		
	CABLE TV			0			0				
	CONTRACT NURSING										
	INTEREST INCOME							(243)			
	NET VENDING COMMISSIONS							(2,535)			
	EMPLOYEE PHYSICAL EXAMS		0				0				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(327,685)		327,685		
	O2 INCOME										
	BAD DEBTS						(107,824)	107,824			
	DISCOUNTS LOST							0			
	ANCILLARIES	454,214							0		
	SETTLEMENT INTEREST										
	RECLASSED SALARIES	0	0	0	0	0	0	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	19,448	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		2,484,596	391,832	535,217	102,358	408,175	873,890	242,068	866,875	5,905,011	2,679,651
PER FINANCIAL STATEMENTS		2,484,596	391,832	535,217	102,358	408,175	873,890	242,068	866,875	(1,808,944)	2,679,651
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										(1,808,944)	

GREENWOOD TERRACE NRSG & REHAB - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		78,383			86505			(8,122)	0		
CENSUS DAYS		39,579			34744			4,835	0		
OCCUPANCY %		50.49%			40.16%				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	533,747	9.71%	13.49	413367	8.94%	11.90	120,380			
Social Services	12-1	44,155	0.80%	1.12	28410	0.61%	0.82	15,745			
TOTAL Health Care and Programs	16-1	1,892,453	34.43%	47.81	1503233	32.52%	43.27	389,220			
Clerical & General Office Expenses	21-1	162,715	2.96%	4.11	99846	2.16%	2.87	62,869			
TOTAL General Administration	28-1	253,451	4.61%	6.40	192749	4.17%	5.55	60,702			
TOTAL Operation Expense	29-1	2,679,651	48.75%	67.70	2109349	45.63%	60.71	570,302			
ADJUSTED TOTALS											
Food	2-8	152,409	2.77%	3.85	154660	3.35%	4.45	(2,251)			
Heat and Other Utilities	5-8	104,302	1.90%	2.64	114754	2.48%	3.30	(10,452)			
Maintenance	6-8	222,098	4.04%	5.61	162474	3.51%	4.68	59,624			
TOTAL General Services	8-8	1,035,314	18.84%	26.16	857800	18.56%	24.69	177,514			
Administrative	17-8	102,364	1.86%	2.59	102650	2.22%	2.95	(286)			
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0			
Professional Services	19-8	168,781	3.07%	4.26	272922	5.90%	7.86	(104,141)			
Fees, Subscriptions, Promotions	20-8	48,926	0.89%	1.24	15131	0.33%	0.44	33,795			
License Fee-IDPA	Pg21	0	0.00%	0.00	0	0.00%	0.00	0			
License Fee-Other	Pg21	330	0.01%	0.01	1063	0.02%	0.03	(733)			
Clerical & General Office Expenses	21-8	349,148	6.35%	8.82	235705	5.10%	6.78	113,443			
Employee Benefits & Payroll Taxes	22-8	391,832	7.13%	9.90	320016	6.92%	9.21	71,816			
Payroll Taxes	Pg21	266,657	4.85%	6.74	203835	4.41%	5.87	62,822			
W/C Insurance	Pg21	4,245	0.08%	0.11	61822	1.34%	1.78	(57,577)			
Health Insurance	Pg21	115,508	2.10%	2.92	49961	1.08%	1.44	65,547			
Inservice Training & Education	23-8	4,166	0.08%	0.11	1418	0.03%	0.04	2,748			
Travel and Seminar	24-8	10,350	0.19%	0.26	7829	0.17%	0.23	2,521			
Other Admin. Staff Transportation	25-8	15,763	0.29%	0.40	17879	0.39%	0.51	(2,116)			
Insurance-Prop.Liab.Malpractice	26-8	160,344	2.92%	4.05	111380	2.41%	3.21	48,964			
Other (specify):*	27-8	0	0.00%	0.00	0	0.00%	0.00	0			
TOTAL General Administration	28-8	1,251,674	22.77%	31.62	1084930	23.47%	31.23	166,744			
TOTAL Operation Expense	29-8	4,319,836	78.59%	109.14	3551047	76.82%	102.21	768,789			
Real Estate Taxes	33-3	48,078	0.87%	1.21	46924	1.02%	1.35	1,154			
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0			
GRAND TOTAL COST	45-8	5,496,400	100.00%	**138.87**	4622774	100.00%	**133.05**	873,626			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2010264	36.57%	**50.79**	1714669.8	37.09%	**49.35**	295,594	#DIV/0!	#DIV/0!	**#DIV/0!**

GREENWOOD TERRACE NRSG & REHAB - DIAGNOSTICS - 12/31/2002

This report DOES NOT REFLECT a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1981 from Page 22 and -4677 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-209264
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-197204
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
#VALUE!
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.